

Mr. Richard Brummel  
December 21, 1992  
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#### 42 CFR 447.253(g) Rates Paid

- The rates paid through the State of Kansas have been determined in accordance with methods and standards specified in the approved Medicaid State Plan.

#### 42 CFR 447.253 Related Information

Estimated Average Rate 10/1/92	\$ 50.99
Estimated Average Rate 7/1/92	50.99
Per Diem Increase	-0-
Average Percent Increase	0%

This amendment clarifies current procedure and does not change the methods and standards of determining payment rates. There is no impact on payment rates.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis.

There are approximately 417 licensed nursing facilities in the State of Kansas with at least one in every county. Of these, approximately 396, or 95% are also certified to participate in the Medicaid Program. There are 24 licensed NFs/MH in the State of Kansas and 100% of them participate in the Medicaid Program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies.

2. To maintain the type of care furnished.

The type of care furnished should be maintained or improved for those recipients needing and receiving care in both the short and long term.

3. To maintain the extent of provider participation.

The extent of provider participation should not be affected by this change. Ninety-five percent of the available providers are already participating in the program.

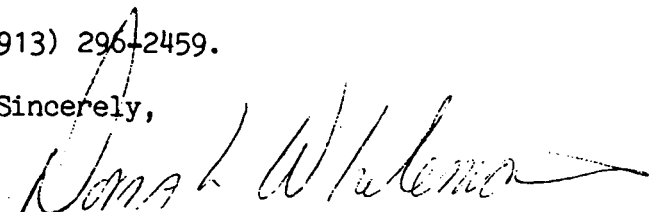
The State of Kansas through this agency, does make assurances that its payment methodology is not reasonably expected to result in an increase in payments based solely on a change in ownership in excess of the increase that would result from application of section 1902(a)(13)(C) of the Social Security Act.

Refers to MS 92-32

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Questions may be directed to Tina Hayes at (913) 296-2459.

Sincerely,



Donna L. Whiteman  
Secretary

DLW:RLE:pm

Enclosure

cc: Steve Otto

Refers to MS 92-32



HE HC  
Wayne  
Tanner

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL  
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

HHS  
HCFA-MEDICAID  
REGION VII  
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October 15, 1993

Richard P. Brummel, Associate Regional Administrator  
Division of Medicaid  
Health Care Financing Administration  
Room 227, Federal Office Building  
601 East 12th Street  
Kansas City, Missouri 64106

RE: FMB:TW KS TN 92-22

Dear Mr. Brummel:

This is in response to your letter, dated November 13, 1992, and other discussions requesting additional information for State Plan Amendment TN 92-22. Items in your letter being addressed are the payment rates and the related assurance for the nursing home reform requirements, the comprehensiveness of our language in Exhibit C-1, and whether or not the rates established on July 1, 1992, were reasonable and adequate. In addition, we will address your request for clarification of certain submitted plan exhibits.

We realize from discussions with your staff and staff of Central Office that you recognize the now unique nature of this review with its plan operations now past and with the availability of retrospective analysis. In these circumstances, you have emphasized an assurance based on an analysis of identified efficiently and economically operated facilities as to a comparison of their costs which must be incurred with actual payments. While continuing to believe that other, related forms of analysis also presented here are of equal import, we refer you to the analysis (Attachment E) discussed on pages ten and eleven. We believe that such analysis supports the assurance that State Plan Amendment TN 92-22 did operate to pay efficiently and economically operated

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facilities their costs which they must (over that time period) incur.

As you requested, please withdraw our earlier assurance statement pertaining to Section 4801(e)(1)(A) of OBRA 1990. In its place, please substitute the following assurance for 42 CFR 447.253 (b)(1)(iii):

CONFIDENTIAL 10/15/93

With respect to nursing facility services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under Section 483.20(f) of Chapter IV, the methods and standards used to determine payment rates take into account the cost of complying with requirements of Part 483 Subpart B of Chapter IV;

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in Section 483.30(c) of Chapter IV to provide licensed nurses on a 24-hour basis;

(C) The State of Kansas establishes procedures under which the data and methodology used in establishing payment rates are made available to the public.

The next concern is a comprehensive description of the methods and standards used to set payment rates. Specifically, Subpart C, Exhibit C-1, Page 4, Paragraph 2, needed a further explanation of our definition of reasonableness and appropriateness as it related to a review of projected cost report items. We agree that the language was not specific. We are requesting that the attached Page 4 of Exhibit C-1 be substituted for our original submission.

For clarification, all projected cost reports are desk reviewed by the SRS Division of Audit Services staff. The rates determined from projected cost reports are subject to the upper payment limits explained in Exhibit C-1. All providers who receive an interim rate from a projected cost report are required to file a historic cost report for the payment period. The historic cost report is

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used to set the new prospective rate, subject to upper payment limits, and to determine a retroactive settlement. The historic cost reports are field audited to verify the accuracy of the information reported.

We are also submitting additional information for Subpart C, Exhibit C-1, pages 13 and 14, concerning the Schedule A historic and estimated inflation and Schedule A-1 historic and estimated inflation. The last paragraph in the revised Exhibit C-1, page 13 clarifies the use of these inflation tables. For correction of Subpart C, Exhibit C-2, Pages 1, 4 and 5, please substitute the attached Pages 1, 4 and 5.

You requested additional information on whether or not the rates set July 1, 1992, were reasonable and adequate after application of the changes to the payment methods and standards, particularly the application of estimated inflation.

In a prospective system, some or all past costs are trended forward to set current payment rates. The historical costs are from cost reports submitted by the providers. This cost information becomes the base from which payment rates are calculated. This base may be reset every several years or annually, as is done in Kansas.

One disadvantage to a prospective system that is rebased annually is the lack of a strong incentive for providers to contain costs. Providers' lack of cost containment is reflected in rapid increases in payment rates.

In the last few years, the nursing home payment rates in Kansas have increased dramatically. The state-wide average payment rate on October 1, 1989 was \$41.66. The average on July 1, 1992 was \$50.99. This represents a total increase of 23% and an average annual increase of 7.67%. During the same time period the Data Resources Incorporated (DRI) skilled nursing facility market basket (SNFMB) inflation index changed a total of 14%, with an average annual increase of 4.67%. This difference would have been greater without the change in inflation methodology adopted through TN 92-22.

Please refer to the enclosed graph charting percentage increases in rates compared to percentage increases in the inflation indices.

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(Attachment A). This graph shows the changes in the DRI-SNFMB inflation index compared to the percentage change in payment rates. The percentage changes in rates have been consistently greater than the percentage changes in the DRI-SNFMB rate. This accelerated increase exists, even after consideration is given to mandates such as OBRA 1987 and minimum wage increases. The effect of annual rebasing is that the rates are increasing approximately 3% per year above the DRI-SNFMB rate. The TN 92-22 methodology was appropriate to hold rate increases to a reasonable level.

When we first received the request for additional information, it was decided to further test the contention that costs, and therefore rates, were increasing at a rate above what could be expected due to the effects of inflation and Federal and State mandates. In this analysis, per diem costs were considered for all cost reports with a rate effective October 1, 1987. For each facility, the per diem costs were inflated to the end of calendar year 1991 using the HCFA Market Basket inflation index published in the Federal Register.

This inflated cost was then compared to the actual December 31, 1991 year end per diem cost.

To account for additional costs incurred in meeting OBRA 1987 requirements and the minimum wage increase, adjustment factors of \$1.80 and \$1.68, respectively, were added to the inflated per diem costs. The \$1.80 was computed by taking the \$1.46 average per diem OBRA add-on increase as calculated by HCFA using data provided by the 50 States and the District of Columbia. This amount was then inflated forward to the end of calendar year 1991.

The \$1.68 for the minimum wage add-on was an amount suggested by a reimbursement committee organized to discuss the impact of the April 1, 1990 and 1991 minimum wage increases on nursing facilities. The committee was composed of representatives from the provider community, the associations as well as state agency personnel. The committee felt that the \$1.68 per day was more than adequate for the minimum wage add-on and the related impact upon the payroll.

The resulting inflated per diem cost plus the adjustment factors were compared to the 12/31/91 per diem cost as reported on the cost

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reports. We have enclosed the detail of the analysis labeled Attachment B. The analysis shows that the average resident day weighted cost reported on 12/31/91 is \$1.27 more than the cost that might be expected by inflating a 1987 base and adjusting for the effect of the minimum wage and OBRA requirements. These increases do not appear to relate to any average case mix index increases.

In addition, the change to a calendar year cost report in 1991 changed the beginning of the limitation period from October 1 to July 1. This decrease in the time period between establishing limitations and setting rates allowed cost increases to impact the system more quickly and artificially accelerated the rate increases.

Stopping the inflationary adjustment at the beginning of the payment period was an effort to bring facility rates more in line with the inflationary increases that would reasonably be expected and to minimize the impact of shortening the time between limitation periods. The impact of the change in the inflation methodology was approximately \$.95 per resident day which, as can be seen by comparing it to the \$1.27 cost override we found in the analysis discussed above, comes close to bringing the recognition of reported costs closer to their reasonable anticipated levels. This adjustment to the payment methodology was anticipated to be temporary for a twelve month period.

We must necessarily note our objections to the statements at the bottom of page 5 and the top of page 6 of your letter as to the requirements that: "the State must define the term 'efficiently and economically operated facility', and second, that the efficiently and economically operated facilities must receive payment from the State at least equal to their costs." This is not in accordance with HCFA regulations, nor with the interpretative statements by HCFA published with the promulgation of 42 C.F.R. Part 447 in 44 FR 56046 et seq. on December 19, 1983.<sup>1</sup> Nor is the cost statement in

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<sup>1</sup> It is the State's understanding that the Federal Register statements remain the HCFA interpretation. More recently the Economist for the American Health Care Association testified in the Preliminary Injunction Hearing of litigation on this plan amendment:

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accordance with the Boren Amendment (42 U.S.C. 1396a(a)(13)(A)) requirements as to "costs which must be incurred".

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Q. Now, you've mentioned defining--I don't know whether to state it in the singular or the plural, but economic and efficiently-operated facilities.

A. Well, I hope that it's plural.

Q. On the definition of-- turning again to Exhibit 13 (sic), of the states indicated here that you participated in meaningful changes effected, on how many of these states was a-- was an explicit definition of efficiently- and economically-operated facilities incorporated?

A. Explicitly?

Q. That's my question.

A. Probably none.

Q. And, in fact, you realize the extreme difficulty of doing so, do you not?

A. Oh, yes. I've wrestled with that problem many times.

Q. And I believe you held a conference with a number of other economists last summer through your association towards exploring such definitions?

A. Some of the best people across the country were invited to that.

Q. And the result was that your association still determined that it was not advisable to recommend adoption of explicit definitions?

A. We were advised, and I-- I tend to agree that it's a very, very difficult problem to come up with a single standard that is universally applicable to identify efficiently and economically-operated from inefficiently- and ineconomically-operated facility. That the present technique of relying on an implicit definition was probably the best, recognizing that all systems have implicit definitions, and some are very bad and some are very good. (Trans. of the Testimony of Robert T. Deane on April 6, 1993, pp. 84-86 in Case No. 93-4045-RDR.)

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The Kansas rate setting process includes a determination of per diem costs based on 85% or greater occupancy, inflation factors, limitations, and incentives. We have included several items, labeled Attachment C, from our findings file to assist in an understanding of this process:

1. Schedule C - Owner/Administrator Limit
2. Schedule E - Incentive Factor
3. Schedule B - Cost Center Limits
4. Schedule D1 - Proforma Rate Calculations  
D2 - Estimate of Fiscal Impact
5. Comparison of the 7/1/92 rates and the prior rates
6. Occupancy Study and Analysis
7. DRI/McGraw-Hill Quarterly Report for 1st quarter 1992
8. Private Pay Rate Reports

The rate payment period in TN 92-22 is now a historical period. This allows us to not only project results, but also assess the impact of the rates established under this plan amendment.

If the State were meeting only the minimum standard - reimbursing costs which must be incurred by the efficiently and economically operated facility - under the operation of the payment methodology, there should be a certain attrition from the program of those whose management does not adhere to the provider requirement of efficiency and economy. An increased attrition if the rates had fallen below the minimum standard would have been anticipated.

In reviewing this period, we have not seen any providers leave the program due to bankruptcy or financial difficulty. In fact, since the implementation of the rates established under TN 92-22, new providers have entered the program who had not participated before: Plaza West Care Center, Topeka; Sharon Lane, Shawnee; and Overland Park Manor, Overland Park.

A quartile analysis, labeled Attachment D, shows weighted average cost coverage during calendar year 1992. In determining the weighted average cost coverage used in these retroanalysis, we have used an even cost allocation across all resident days regardless of payment source. This approach has an allocation bias that favors the providers. For example, in Kansas, as in other states the average case mix index (CMI), as measured by the Resource

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Utilization Groups Version III (RUG-III) hierarchy, for non-Medicaid residents is higher than the CMI for Medicaid residents. The average CMI for Kansas Medicaid residents is 9.6% lower. This differential indicates that expenses are higher for non-Medicaid residents in general. However, current methodology allows costs to be spread equally over all resident days. RUG-III was developed to predict usage of the health care dollar. An allocation for health care costs based on the CMI of the various resident populations would be more representative of the cost of care.

Also, certain plant operating, administration, and room and board costs might be more accurately allocated by a methodology other than even cost distribution to account for private rooms occupied by other than Medicaid residents. Facilities with low Medicaid occupancy are less reliant on the reimbursement system and less responsive to cost containment components. Spending patterns may also vary in attempts to attract private pay residents. Such impacts should be noted although they are difficult to quantify.

Measurement of cost coverage is further complicated by timing differences between rate years July 1 to June 30 and the available cost information, the calendar year cost report. Each retrospective analysis contains rate information from two rate periods.

Another consideration is that depreciation is not a cost requiring an expenditure of cash. It is a method for allocation of capital expenditures which may be overstated -- particularly during periods when property values are appreciating or remaining stable.

It is impossible to determine whether particular allowable costs are costs which must be incurred without an on-site efficiency audit. There are a variety of potentially excessive or otherwise unnecessary costs that facilities incur (such as luxury automobiles, as recent depositions have shown) that are not evident from cost reports or cost comparisons, but that certainly are not costs which must be reimbursed under the Medicaid program. Our cost coverage analysis necessarily includes some such costs.

Even with the measurement bias and potential cost overstatements, payment rates covered approximately 89% of aggregate unaudited allowable costs. The weighted average cost coverage for facilities